emailed validation letter 11/30/11

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 11.3.11
Amount $885.-
Ck# 14825

I. IDENTIFICATION

Name: Hicks Golden Years Nursing Home
Address: 1901 W. Hwy 90
City/County/Zip: Monticello Wayne 42633
Telephone number: 606 348-6034
Administrator: Darrell Hicks DarrellWHicks@hotmail.com
Date facility operation began at current address: 12.6.77
Date facility began operation under current owner: 04-11-02

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	59	59
Intermediate Care	~~59~~	~~59~~
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

(State) / County / City / Private

(Profit) / Nonprofit

Individual / Partnership / (Corporation) LLC

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Hicks Enterprises of Monticello, LLC
1901 W. Hwy 90
Monticello Ky 42633

RECEIVED
NOV 03 2011
OFFICE OF INSPECTOR GENERAL

11/30 R.B.

(OVER)

If facility owned or leased by a corporation, complete the following:

Name of corporation Hicks Enterprises of Monticello, LLC

Address of corporation 1901 W. Hwy 90 Monticello Ky 42633

President or Chairman Darrell Hicks adm. Pres.

Vice President _____

Secretary Debbie Tucker

Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
NA	NA

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Signature of authorized representative — Title: adm. Pres. — Date: 11/1/2011

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)